Dentist 4 | Better bites, better smiles, better life.
better quality of life

D4-CONSENT FORMS - SCALING & ROOT PLANNING

PROCEDURE INFORMATION

PATIENT NAME:

LAST | FIRST | MI | DATE OF BIRTH

PROCEDURE: **SCALING AND ROOT PLANNING (SRP)**

PROCEDURE | TEETH (S)

DOCTOR NAME:

COMPLETE NAME

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

DETAILS OF CONSENT

Condition

My doctor has explained the nature of my condition to me: periodontal disease in all or some areas of my mouth. I understand that periodontal disease weakens the support of my teeth by separating the gum from the teeth and destroying some of the bone that supports the tooth roots. I have been made aware of the fact that if left untreated, periodontal disease can cause me to lose my teeth and I can have other adverse consequences to my general health.

Procedure – Scaling and Root Planning

My doctor and my Hygienist has proposed the following procedure to treat or diagnose my condition: Scaling and Root Planning, In order to treat my periodontal condition, the Doctor has recommended that my treatment include scaling and root planning with local anesthetic. The purpose of this therapy is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my condition may require additional treatment that may include a second deep cleaning, periodontal surgery, or antibiotics. You need to schedule an appointment when the hygienist decided to have a new evaluation of your condition. Also, you should brush and floss daily, receive periodontal maintenance as directed, follow a healthy diet, avoid tobacco products and follow proper home care.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of dental procedures and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental professionals.

I understand that I will receive a local anesthetic and/or other medications. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. In case of swallowing or aspiration of a foreign object, a chest x-ray and examination by my medical doctor may be necessary to determine the location of the object and proper treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

Alternatives

It is important to consider all options very carefully and to find what actually works well long term (results as demonstrated by real case studies and published research). In addition, it is also important to consider how a particular treatment fits into overall goals, expected outcomes, lifestyle, convenience, comfort, and budget. Knowledge is empowering, we encourage all periodontal sufferers researching periodontal treatment options to consider all this information carefully. My doctor has explained the following medically acceptable alternatives to be: Regenerative Periodontal Endoscopy- RPE, Soft Tissue Lasers**,** Local Delivery Antimicrobials**,** Periodontal Surgery (Osseous, Flap, and Regenerative). I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

Consequences of not having procedure

I understand that periodontal disease weakens the support of my teeth by separating the gum from the teeth and destroying some of the bone that supports the tooth roots. I have been made aware of the fact that if left untreated, periodontal disease can cause me to lose my teeth and I can have other adverse consequences to my general health.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor and the hygienist will give the best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are:

- Swelling, pain, and bleeding after treatment.
- Gum recession and root exposure.
- Sensitivity to hot, cold, and sweets.
- Infection.
- Increased spacing and food impaction between teeth.
- Initial looseness of teeth. Most will tighten up, but not all will.
- Numbness in the tissues.

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection.

No guarantee

There is no method currently available that will predict how the gum and bone will heal following any periodontal procedure. Because each patient's condition is unique, long-term success may not occur. In addition, the success of treatment can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, medications, and inadequate oral hygiene. I understand that after the proposed treatment has been completed, a constant monitoring of my condition will be necessary. This will mainly consist of regular 3 month recall visits to the office. I understand that my personal oral hygiene is the key to the prevention and successful treatment. If satisfactory plaque control is not maintained, recurrence of periodontal disease is likely.

MY RESPONSIBILITY

I agree to cooperate completely with the doctor's and hygienist's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following Scaling and root planning. It is my responsibility to see the doctor at least once a year for evaluation and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

MISCELLANEOUS

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation, and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

SIGNATURE

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. _____ to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

Patient or Representative Signature **Date**

If not the patient, what is your relationship to the patient?

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

Dentist Signature **Date**